MaineCare Services
An Office of the
Department of Health and Human Services
John E. Baldacci, Governor
Brenda M. Harvey, Commissioner

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June 15, 2009

TO: Interested Parties

FROM: Anthony Marple, Director, MaineCare Services

SUBJECT: **Final Rule**: MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institutions, and Appendices B, D, E, and F.

This letter gives notice of a final rule for MaineCare Benefits Manual, Chapter III, Section 97, Private Non-Medical Institutions, and Appendices B, D, E, and F. These major substantive rules have been in effect by emergency rule since August 2008 and have been finally approved by the Maine State Legislature.

In this rulemaking, the Department eliminated language about and codes for bedhold days. Bedhold day codes were eliminated from Chapter III, including BQL, BRL, MRPL, RHL RHL9, RML RML2, RTSL, and PL. Some language regarding occupancy rates was also eliminated from Appendices B, D, E, and F. HIPAA compliant codes have been adopted that will not be effective until the Department's new claims processing system is operational. Providers will be given prior notice of the change of these billing codes.

Rules and related rulemaking documents may be reviewed at and printed from the Office of MaineCare Services website at http://www.maine.gov/dhhs/oms/rules/provider_rules_policies.html or, for a fee, interested parties may request a paper copy of rules by calling 207-287-9368. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 1-800-423-4331.

A copy of the public comments and Department responses can be viewed at and printed from the Office of MaineCare Services website or obtained by calling 207-287-9368 or TTY: (207) 287-1828 or 1-800-423-4331.

If you have any questions regarding the policy, please contact your Provider Relations Specialist at 624-7539, option 8 or 1-800-321-5557, extension option 8 or TTY: (207)287-1828 or 1-800-423-4331.

Notice of Agency Rule-making Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: MaineCare Benefits Manual, Chapter III, Section 97, and Appendices B, D, E, and F, Private Non-Medical Institution Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: These rules permanently adopt emergency rules already in place that have recently been approved by the Maine State Legislature in LR 1883(03). The rules eliminate bedhold day reimbursement for PNMI services. Specific changes in these rules include that bedhold day codes are eliminated from Chapter III, including BQL, BRL, MRPL, RHL RHL9, RML RML2, RTSL, and PL. Some language regarding occupancy rates was also eliminated from Appendices B, D, E, and F. The Department also replaced some local codes with HIPAA-compliant standard codes that will not be implemented until further notice when the new claims system is operating. Providers will be given prior notice of the change for these billing codes.

See http://www.maine.gov/oms/rules/provider_rules_policies.htm for rules and related rulemaking documents.

EFFECTIVE DATE: July 2, 2009

AGENCY CONTACT PERSON: Patricia Dushuttle, Manager,
Division of Policy and Performance

AGENCY NAME: 442 Civic Center Drive
11 State House Station
Augusta, ME 04333-0011

10000 GENERAL DEFINITIONS (cont.)

Services," or "Rules for the Licensure of Residential Child Care Facilities/Rights of Recipients of Mental Health Services Who are Children in Need of Treatment;" and the Federal Certification requirements for Private Non-Medical Institutions that are in effect at the time the cost is incurred.

Eff 7/2/09

"Leave (bedhold) days" are when the resident is not in the facility and no treatment is provided. Leave days are not a covered service.

* TO BE EFFECTIVE UPON FURTHER NOTICE*

PROC. CODE	**DESCRIPTION** * These codes are subject to change with the implementation of the new claims system. Proposed replacement codes are listed for each category. Providers will be given notification of use of new codes at least thirty days prior to implementation. New codes will not be used until then.	**MAXIMUM ALLOWANCE**
SUBSTANCE ABUSE TREATMENT FACILITIES		
PNMI* (H0010)	Detoxification	By Report
RH4* (H0011)	Halfway House Services	By Report
RH5* (H0012)	Extended Care Shelters	By Report
RH6* (H0013)	Residential Rehabilitation	By Report
RH7* (H0012)	Extended Shelter	By Report
RH8* (H0013)	Adolescent Residential Rehabilitation	By Report
RH9* (T1020)	Personal Care-Substance Abuse	By Report
~~RHL1*~~	~~Substance Abuse Leave Days (RH4, RH5, RH7, RH8)~~	~~By Report~~
~~RHL9*~~	~~Substance Abuse Leave Days (RH9)~~	~~By Report~~

RESIDENTIAL CHILD CARE FACILITY		
~~RTS*~~	~~Child Care Facility Services~~	~~By Report~~
~~RTSL*~~	~~Child Care Facility Leave Days~~	~~By Report~~

COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL ILLNESS		
RMI* (H0019)	Rehabilitation Services	By Report
RMI2* (H0020)	Personal Care Services-Residences For People With Mental Illness	By Report
~~RML*~~	~~Leave Days for People with Mental Illness (RMI)~~	~~By Report~~
~~RML2*~~	~~Leave Days for People with Mental Illness (RMI2)~~	~~By Report~~
RESIDENTIAL CARE FACILITIES		
BQ* (T1020)	Medical and Remedial Personal Care Services	By Report
~~BQL*~~	~~Medical and Remedial Personal Care Services Leave Days~~	~~By Report~~
BP* (T1020)	Medical And Remedial (Personal Care) Services	By Report
~~PL*~~	~~Medical And Remedial Services Leave Days~~	~~By Report~~
COMMUNITY RESIDENCES FOR PEOPLE WITH MENTAL RETARDATION		
RMR* (T1020)	Personal Care Services-Residences For People With Mental Retardation	By Report

MRP* (H0019)	PNMI Services	By Report
~~RMRL~~	~~Personal Care Leave Days~~	~~By Report~~
~~MRPL*~~	~~PNMI Leave Days~~	~~By Report~~

APPENDIX B	SUBSTANCE ABUSE TREATMENT FACILITIES	Established 1/1/85 Last Updated 7/2/09

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APPENDIX B SUBSTANCE ABUSE TREATMENT FACILITIES Established1/1/85
Last Updated 7/2//09

INTRODUCTION

1000 PURPOSE

The purpose of Appendix B is to identify reimbursement regulations that are specific to substance abuse treatment facilities under Chapter III, Private Non-Medical Institutions (PNMI) services of the MaineCare Benefits Manual. The general provisions of Chapter III for PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for private non-medical institutions. These regulations identify which costs are reimbursable within Section 97, Chapters II and III and Appendix B, Private Non-Medical Institution Services of the MaineCare Benefits Manual.

1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds which may be available from State and/or Federal sources for the provision of the services as set forth in Appendix B is contained in 22 MRSA Section 3173-D and Title XIX of the Social Security Act as Amended; 42 U.S.C.A. §1396 et. seq.

1210 DEFINITIONS

The term “member” as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving substance abuse treatment by qualified staff of a Private Non-Medical Institution as defined in Section 97.01-1(A) of the MaineCare Benefits Manual.

The term “facility” as used throughout these Principles of Reimbursement refers to private non-medical institutions licensed and funded by the State of Maine, Department of Health and Human Services (DHHS) Office of Substance Abuse Services (OSA) under Sections 4.06, 4.08, 4.09, 4.10, 4.11 and/or 4.13 of the "Regulations for Licensing/Certifying of Substance Abuse Treatment Facilities in the State of Maine," but excludes any Department-licensed facilities staffed by a solo provider.

APPENDIX B SUBSTANCE ABUSE TREATMENT FACILITIES Established 1/1/85
Last Updated 7/2/09

2400 ALLOWABILITY OF COST

2400.1 Allowable costs shall include salaries and wages for direct service staff and services listed below:

Physicians
Psychiatrists
Psychologists
Social workers
Licensed clinical professional counselors
Licensed professional counselors
Registered nurses
Practical nurses
Licensed alcohol and drug counselors
Psychiatric nurses
Personal care services staff
Certified interpreters
Clinical Consultants
Other qualified alcohol and drug treatment staff as defined in Section 97.07-2, of the MaineCare Benefits Manual.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet members' needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.11 The Department shall determine the reasonableness of the treatment costs on an annual basis.

2400.2 Allowable costs shall also include the taxes and fringe benefits; as defined in Chapter III, Subsection 2400.2.

2400.3 Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by OSA and OMS. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services.

2450 Program Allowance: A program allowance, expressed as a percentage of the allowable costs in Sections 2400.1 through 2410 will be allowed in lieu of indirect and/or PNMI related cost. The program allowance, as set forth in Chapter III, Section 97, is 35%.

APPENDIX B SUBSTANCE ABUSE TREATMENT FACILITIES Established 1/1/85
Last Updated 7/2/09

2400 ALLOWABILITY OF COST (cont.)

2460 The total allowable costs shall be allocated to rehabilitation and to personal care.

2500 NON-ALLOWABLE COSTS

Non-allowable cost includes all costs not included in Section 2400.

3400 SETTLEMENT OF COST REPORTS

3400.1 Uniform Desk Review

3400.11 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded therein, and allowable costs.

3400.13 Based on the results of the uniform desk review, the Division of Audit shall:

a. Request more information,
b. Issue a final settlement, or
c. Conduct a field audit and issue a final settlement.

3400.2 Calculation of Final Settlement

3400.21 The total actual costs of the facility shall be determined in accordance with Section 2400 in Chapter III and this Appendix.

3400.22 The total cost cap approved in the facility budget shall be determined in accordance with Section 6000 of this Appendix.

3400.23 The allowable cost shall be limited to the lesser of the total actual cost of the facility, which includes the State-mandated service tax, or the sum of the total cost cap approved in the facility budget, plus the State-mandated service tax and the program allowance on the service tax.

EFF 7/2/09

3400.24 To determine the allowable cost per bed day, the allowable cost shall be divided by the total actual days of care.

APPENDIX B SUBSTANCE ABUSE TREATMENT FACILITIES Established 1/1/85
Last Updated 7/2/09

3400 SETTLEMENT OF COST REPORTS (Cont)

3400.25 The allowable cost per bed day shall be multiplied by MaineCare eligible days to determine the reimbursable MaineCare cost.

3400.26 Final settlement: The reimbursable MaineCare cost, determined through the audit, shall be compared to the interim payments to determine an overpayment or underpayment.

5120 PERSONAL CARE SERVICES

PNMI services approved and funded by OSA in licensed facilities may also provide personal care services necessary for the promotion of ongoing treatment and recovery. PNMI facilities must be receiving funds from OSA, specifically for the provision of personal care services, in order to also be reimbursed by MaineCare for such services.

6000 RATE SETTING

6000.1 Payment rates and the total cost cap are established prospectively by the OMS and the Department for each facility based on approved budgeted costs for the provider's fiscal year. The approved budget is based on a rate setting report submitted to the OMS and OSA by the provider prior to the beginning of the provider's fiscal year. The budget shall be submitted on forms/media prescribed by the OMS and OSA.

6000.2 The provider must also submit, upon request, such data, statistics, schedules, or other information required by the OMS and OSA.

6000.3 The rate for the previous period will remain in effect until a new rate is approved. Retroactive rate adjustments shall not be granted, unless approved by the OMS and OSA under exceptional circumstances as determined by these two agencies.

6000.4 The new rate will be effective for services provided from the first day of the month following the budget approval from OMS and OSA.

6000.5 Providers must submit a rate setting report and any required supporting documentation for each PNMI at least 60 days prior to the start of the provider's fiscal year. The inclusive dates of the rate setting period shall be the inclusive dates of the cost reporting period as prescribed by Chapter III, Section 3300.3.

6000.6 The OMS and OSA may issue guidelines to assist providers in developing their budgets for the agreement period.

6000 RATE SETTING (cont.)

6000.7 The total allowable costs for the budget period, based on prior year actual allowable costs, current year costs and funding levels, and pre-approved changes expected in the budget period, as reported by the provider, are used to determine the level of reasonable costs to be recognized in setting the prospective rate and total cost cap for the budget period. Only costs that are allowable pursuant to Section 2400 are included in calculating the prospective rate.

Eff. 7/2/09

6000.8 Approval of the prospective rate and the total cost cap is at the discretion of the OMS and OSA. The OMS and OSA may make adjustments modifying the provider's proposal.

6000.9 Calculation of the prospective rate: the total cost cap shall be divided by the estimated annual occupancy, which in no instance will exceed the facility's actual licensed capacity.

7000 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX B

Providers may request rate adjustments as necessary. The following section details the process for such requests. No retroactive rate adjustments will be granted.

7000.1 Process for Requesting Rate Adjustments for Providers Covered Under Appendix B:

7000.12 To request a rate adjustment, the provider will submit an approved and revised budget on a OMS-approved form to the OMS and to OSA. The provider will attach a narrative detailing the reasons for the requested adjustment, the new rate, and the total cost of the requested rate adjustment for the remainder of the fiscal year.

7000.13 The provider will designate a responsible individual as a primary contact for the OMS and OSA.

7000.14 The rate adjustment submittal date will be the date received by OSA or no more than seven days after the postmark date.

7000.15 The OMS and OSA will reach a decision within 30 calendar days of the rate adjustment submittal date.

7000.16 If a rate adjustment is approved, the effective date shall be the first day of the month following the rate adjustment submittal date.

APPENDIX B	SUBSTANCE ABUSE TREATMENT FACILITIES	Established 1/1/85 Last Updated 7/2/09

7000 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX B (cont.)

7000.17 If the OMS denies the initial request, or requires additional information, the provider shall have 5 working days upon receipt to provide additional information. The OMS shall consider the additional information and make a final determination within 20 working days of receipt of the additional information.

APPENDIX D	CHILD CARE FACILITIES	Established 1/1/85 Last Updated 7/2/09

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APPENDIX D	CHILD CARE FACILITIES	Established 1/1/85 Last Updated 7/2/09

1000 PURPOSE

The purpose of Appendix D is to identify reimbursement regulations that are specific to residential child care facilities, child placing agencies, treatment foster care providers, or Intensive Temporary Out of Home Treatment Services providers under Section 97, Chapter III, Private Non-Medical Institutions (PNMI) services of the MaineCare Benefits Manual. The general provisions of Chapter III for PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for Private Non-Medical Institutions. This Appendix identifies which costs are reimbursable within Section 97, Chapters II and III and Appendix D, Private Non-Medical Institution Services of the MaineCare Benefits Manual. These regulations apply to reimbursement for PNMI services beginning the first day of the provider's fiscal year beginning on or after July 1, 2001.

1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds that may be available from State and Federal sources for the provision of the services set forth in this Appendix of Reimbursement is contained in 22 MRSA Sec. 42 and Sec. 3173.

1210 DEFINITIONS

The term "member" as used throughout this Appendix refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving mental health treatment and/or rehabilitative services as a resident of a child care facility as defined in Section 97.01-1(B) of the MaineCare Benefits Manual.

The term "facility" as used throughout these Principles of Reimbursement refers to a child care facility, as defined by Section 97.01-1(B) of the MaineCare Benefits Manual. Also, as stated in Section 97.01-1(B) for MaineCare reimbursement purposes, this term also includes child placing agencies and treatment foster care providers.

APPENDIX D CHILD CARE FACILITIES Established 1/1/85
Last Updated 7/2/09

2400 ALLOWABILITY OF COST

2400.1 Allowable costs shall include salaries and wages for direct service staff and services listed below:

Physicians
Psychiatrists
Psychologists
Psychological examiners
Licensed clinical professional counselors
Licensed professional counselors
Dentists
Registered nurses
Licensed social workers
Licensed clinical social workers
Speech pathologists
Occupational therapists
Clinical consultants
Other qualified child care facility staff
Other qualified mental health staff
Interpreters
Psychiatric nurses
Practical nurses
Physician's assistants
Licensed practical nurses
Licensed alcohol & drug counselors
Licensed nurse practitioners
Other qualified alcohol & drug treatment staff, as defined in Section Chapter II, Section 97.07-2, of the MaineCare Benefits Manual.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet resident needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.11 The Department shall determine the reasonableness of the treatment costs on an annual basis.

2400.2 Allowable costs shall also include the taxes and fringe benefits, as defined in Chapter III, Section 2400.2.

APPENDIX D	CHILD CARE FACILITIES	Established 1/1/85 Last Updated 7/2/09

2400 ALLOWABILITY OF COST (cont.)

2400.3 Other qualified treatment foster care providers (Chapter 2, Section 97.07-2 of the MaineCare Benefits Manual). Reimbursement to foster parents for care of children in placement shall be limited to 60% of the wages and taxes/fringe benefits (as defined under Sections 2400.1 and 2400.2 of this Appendix) or 60% of the stipend amounts as determined by the Department.

2400.4 Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior approved by the Department. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a 5% tax the value of PNMI services.

2450 A program allowance of 35%, expressed as a percentage of the allowable costs in Sections 2400.1 through 2410 will be allowed in lieu of indirect and/or PNMI related cost. The program allowance, as set forth in Chapter III, Section 97, is a percentage specific to this Appendix and is applicable to all facilities covered under this Appendix.

The Commissioner will determine the program allowance based on the overall cost structure of the type of PNMI.

2500 NON-ALLOWABLE COSTS

A non-allowable cost includes all costs not included in Section 2400.

3400 SETTLEMENT OF COST REPORTS

3400.1 Uniform Desk Review

3400.11 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, and allowable costs.

3400.13 Based on the results of the uniform desk review, the Division of Audit shall:

1. Request more information,
2. Issue a final settlement, or
3. Conduct a field audit and issue a final settlement.

APPENDIX D CHILD CARE FACILITIES Established 1/1/85
Last Updated 7/2/09

3400 SETTLEMENT OF COST REPORTS (cont.)

3400.2 Calculation of Final Settlement

3400.21 The total actual costs of the facility shall be determined in accordance with Section 2400 in Chapter III and this Appendix.

3400.22 The total cost cap approved in the facility budget shall be determined in accordance with Section 6000 of this Appendix.

3400.23 The allowable cost shall be limited to the lesser of the total actual cost of the facility, which includes the State-mandated service tax, or the sum of the total cost cap approved in the facility budget plus the State-mandated service tax and program allowance on the service tax.

EFF 7/2/09

3400.24 To determine the allowable cost per bed day, the allowable cost shall be divided by the total actual days of care.

3400.25 The allowable cost per bed day shall be multiplied by MaineCare eligible days to determine the reimbursable MaineCare cost.

3400.26 Final settlement: The reimbursable MaineCare cost, determined through the audit, shall be compared to the interim payments to determine an overpayment or underpayment.

6000 RATE-SETTING

6000.1 Payment rates and the total cost cap are established prospectively by the OMS and Department for each facility based on approved budgeted costs for the provider's fiscal year. The approved facility budget is based on a rate setting report submitted to the OMS and Department by the provider prior to the beginning of the provider's fiscal year. The budget shall be submitted on forms/media prescribed by the OMS and Department.

6000.2 The provider must also submit, upon request, such data, statistics, schedules, or other information that the OMS and Department requires.

6000.3 The rate for the previous period will remain in effect until a new rate is approved.

Retroactive rate adjustments shall not be granted, unless approved by the OMS and Department under exceptional circumstances.

APPENDIX D CHILD CARE FACILITIES Established 1/1/85
Last Updated 7/2/09

6000 RATE-SETTING (cont.)

6000.4 The new rate will be effective for services provided from the first day of the month following the budget approval from OMS and the Department.

6000.5 Providers must submit a rate setting report and any required supporting documentation for each facility at least 60 days prior to the start of the provider's fiscal year. The inclusive dates of the rate setting period shall be the inclusive dates of the cost reporting period as prescribed by Chapter III, Section 3300.3.

6000.6 The OMS may issue guidelines to assist providers in developing their budgets for the agreement period.

6000.7 The total allowable costs for the budget period, based on prior year actual allowable costs, current year costs and funding levels, and pre approved changes expected in the budget period, as reported by the provider, are used to determine the level of reasonable costs to be recognized in setting the prospective rate and total cost cap for the budget period. Only costs that are allowable pursuant to Section 2400 are included in calculating the prospective rate.

6000.8 Approval of the prospective rate and the total cost cap is at the discretion of the OMS and the Department. The OMS may make adjustments modifying the provider's proposal.

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6000.9 Calculation of the prospective rate: the total cost cap shall be divided by the estimated annual occupancy.

7000 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX D:

Providers may request rate adjustments as necessary. The following Section details the process for such requests. No retroactive rate adjustments will be granted.

7000.1 Process for Requesting Rate Adjustments for Providers Covered Under Appendix D:

7000.12 To request a rate adjustment, the provider will submit an approved and revised budget on a OMS-approved form to the OMS and to the Department. The provider will attach a narrative detailing the reasons for the requested adjustment, the new rate, and the total cost of the requested rate adjustment for the remainder of the fiscal year.

7000.13 The provider will designate a responsible individual as a primary contact for the OMS and the Department.

APPENDIX D CHILD CARE FACILITIES Established 1/1/85
Last Updated 7/2/09

7000 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX D: (cont.)

7000.14 The rate adjustment submittal date will be the date received by the Department or no more than seven days after the postmark date.

7000.15 The OMS and the Department will reach a decision within 30 calendar days of the rate adjustment submittal date.

7000.16 If a rate adjustment is approved, the effective date shall be the first day of the month following the rate adjustment submittal date.

7000.17 If the OMS denies the initial request, or requires additional information, the provider shall have 5 working days upon receipt to provide additional information. The OMS shall consider the additional information and make a final determination within 20 working days of receipt of the additional information.

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 7/2/09

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APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 7/2/09

1000 PURPOSE

The purpose of Appendix E is to identify reimbursement regulations that are specific to residential treatment facilities for persons with mental illness. The general provisions of MaineCare Benefits Manual, Chapter III, Section 97, PNMI services contain reimbursement regulations that are applicable to all categories of service under the PNMI regulations. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on reimbursement for private non-medical institutions. This Appendix identifies which costs are reimbursable within Section 97, Chapter II and III, Private Non-Medical Institution Services of the MaineCare Benefits Manual. These regulations apply to reimbursement for PNMI services beginning the first day of the provider's fiscal year beginning on or after July 1, 2001.

1200 AUTHORITY

The authority of the Department of Health and Human Services to accept and administer funds that may be available from State and Federal sources for the provision of services set forth in these Principles of Reimbursement is contained in 22 M.R.S.A. §42, §3173.

1210 DEFINITIONS

The term resident as used throughout Appendix E refers to an individual who has been determined to be eligible for MaineCare by the Department of Health and Human Services and who is receiving mental health treatment and/or rehabilitative services and/or personal care services as a resident of a residential treatment facility for persons who experience mental illness, as defined in Section 97.01-1 (C) of the MaineCare Benefits Manual.

The term "facilities" as used throughout Appendix E refers to residential treatment facilities for persons who experience mental illness, or residences for the integrated treatment of persons with dual disorders, as defined in Section 97.01-1(C) of the MaineCare Benefits Manual.

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 7/2/09

2400 ALLOWABILITY OF COST

2400.1 Allowable costs shall include salaries and wages for direct service staff and services listed below:

Physicians
Psychiatrists
Psychologists
Social workers
Psychiatric nurses
Psychological examiners
Occupational therapists
Other qualified mental health staff
Personal care service staff
Clinical consultants
Licensed substance abuse staff
Licensed clinical professional counselors
Licensed professional counselors
Other qualified alcohol and drug treatment staff, as defined in Chapter II, Section 97.07-2, of the MaineCare Benefits Manual.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet members' needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.11 The Department shall determine the reasonableness of the treatment costs on an annual basis.

2400.2 Allowable costs shall also include the taxes and fringe benefits, as defined in Chapter III, Section 2400.2.

2400.4 Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by the Department. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State- mandated service tax is a 5% tax on the value of PNMI services.

2450 A program allowance of 35%, expressed as a percentage of the allowable costs in Sections 2400.1 through 2410 will be allowed in lieu of indirect and/or PNMI related cost. The program allowance, as set forth in Chapter III, Section 97, is a percentage specific to this Appendix and is applicable to all facilities covered under this Appendix.

APPENDIX E COMMUNITY RESIDENCES FOR PERSONS WITH MENTAL ILLNESS Established 3/1/88
Last Updated 7/2/09

2400 ALLOWABILITY OF COST (cont.)

2460 The total allowable costs shall be allocated to rehabilitation and to personal care.

2500 NON-ALLOWABLE COSTS

A non-allowable cost includes all costs not included in Section 2400.

3400 SETTLEMENT OF COST REPORTS

3400.1 Uniform Desk Review

3400.11 The Division of Audit shall perform a uniform desk review of each acceptable cost report submitted.

3400.12 The uniform desk review is an analysis of the provider's cost report to determine the adequacy and completeness of the report, accuracy and reasonableness of the data recorded thereon, and allowable costs.

3400.13 Based on the results of the uniform desk review, the Division of Audit shall:

1. Request more information
2. Issue a final settlement, or
3. Conduct a field audit and issue a final settlement.

3400.2 Calculation of Final Settlement

3400.21 The total actual costs of the facility shall be determined in accordance with Section 2400 in Chapter III and this Appendix.

3400.22 The total cost cap approved in the facility budget shall be determined in accordance with Section 6000 of this Appendix.

3400.23 The allowable cost shall be limited to the lesser of the total actual cost of the facility, which includes the State-mandated service tax, or the sum of the total cost cap approved in the facility budget plus the State-mandated service tax and program allowance on the service tax.

3400.24 To determine the allowable cost per bed day, the allowable cost shall be divided by the total actual days of care.

EFF 7/2/09

3400.25 The allowable cost per bed day shall be multiplied by MaineCare eligible days to determine the reimbursable MaineCare cost.

3400 SETTLEMENT OF COST REPORTS (cont.)

3400.26 Final settlement: The reimbursable MaineCare cost, determined through the audit, shall be compared to the interim payments to determine an overpayment or underpayment.

5120 PERSONAL CARE SERVICES

PNMI services approved and funded by the Department of Health and Human Services- Adult Mental Health Services in licensed facilities may also provide personal care services necessary for the promotion of ongoing treatment and recovery. PNMIs must be receiving funds from the Department, specifically for the provision of personal care services, in order to also be reimbursed by MaineCare for such services.

6000 RATE-SETTING

6000.1 Payment rates and the total cost cap are established prospectively by the OMS and Department for each facility based on approved budgeted costs for the provider's fiscal year. The approved facility budget is based on a rate setting report submitted to the OMS and Department by the provider prior to the beginning of the provider's fiscal year. The budget shall be submitted on forms/media prescribed by the OMS and Department.

6000.2 The provider must also submit, upon request, such data, statistics, schedules, or other information that the OMS and Department requires.

6000.3 The rate for the previous period will remain in effect until a new rate is approved. Retroactive rate adjustments shall not be granted, unless approved by the OMS and Department under exceptional circumstances as determined by these two agencies.

6000.4 The new rate will be effective for services provided from the first day of the month following the OMS and budget approval from the Department.

6000.5 Providers must submit a rate setting report and any required supporting documentation for each facility at least 60 days prior to the start of the provider's fiscal year. The inclusive dates of the rate setting period shall be the inclusive dates of the cost reporting period as described by Chapter III, Section 3300.3.

6000.6 The OMS and Department may issue guidelines to assist providers in developing their budgets for the agreement period.

6000.7 The total allowable costs for the budget period, based on prior year actual allowable costs, current year costs and funding levels, and pre approved changes expected in the budget period, as reported by the provider, are used to determine the level of

6000 RATE-SETTING (cont.)

reasonable costs to be recognized in setting the prospective rate and total cost cap for the budget period. Only costs that are allowable pursuant to Section 2400 are included in calculating the prospective rate.

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6000.8 Approval of the prospective rate and the total cost cap is at the discretion of the OMS and Department. The OMS and Department may make adjustments modifying the provider's proposal.

6000.9 Calculation of the prospective rate: the total cost cap shall be divided by the estimated annual occupancy.

7000 RATE ADJUSTMENTS FOR PROVIDERS UNDER APPENDIX E

Providers may request rate adjustments as necessary. The following section details the process for such requests. No retroactive rate adjustments will be granted.

7000.1 Process for Requesting Rate Adjustments for Providers Covered Under Appendix E:

7000.12 To request a rate adjustment, the provider will submit an approved and revised budget on a OMS-approved form to the OMS and to the Department. The provider will attach a narrative detailing the reasons for the requested adjustment, the new rate, and the total cost of the requested rate adjustment for the remainder of the fiscal year.

7000.13 The provider will designate a responsible individual as a primary contact for the OMS and the Department.

7000.14 The rate adjustment submittal date will be the date received by the Department or no more than seven days after the postmark date.

7000.15 The OMS and the Department will reach a decision within 30 calendar days of the rate adjustment submittal date.

7000.16 If a rate adjustment is approved, the effective date shall be the first day of the month following the rate adjustment submittal date.

7000.17 If the OMS denies the initial request, or requires additional information, the provider shall have 5 working days upon receipt to provide additional information. The OMS shall consider the additional information and make a final determination within 20 working days of receipt of the additional information.

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1000 INTRODUCTION

1010 Purpose. The purpose of this Appendix is to define the payment mechanism for Title XIX funds in medical and remedial services facilities under Section 97, Chapter II, Private Non-Medical Institution (hereinafter PNMI) Services of the MaineCare Benefits Manual, that are exempt from Appendix C. It shall be the prerogative of the Commissioner of the Department of Health and Human Services to impose a ceiling on all or a portion of reimbursement for PNMIs provided by their Departments. These regulations identify those costs that are covered under this Section and the method of payment.

1020 Authority. The authority of the Maine Department of Health and Human Services to accept and administer funds that may be available from private, local, State, or Federal sources for the provision of services set forth in this Appendix is established in Title 22 of the Maine Revised Statutes Annotated, §3, §10, §42, §3273, §7906-A and 7910. The Department of Health and Human Services issues these regulations pursuant to authority granted by Title 22 of the Maine Revised Statutes Annotated §42(1).

1030 Principle. In order to receive reimbursement according to this Appendix, a facility must be licensed as a residential care facility and have a provider contract specifying the conditions of participation in Title XIX as a Private Non-Medical Institution as described in Section 97, Chapter II of the MaineCare Benefits Manual, except for scattered site facilities for persons with mental retardation, which may be licensed either as a residential care facility or as a mental health provider in accordance with The Mental Health Agency Licensing Standards and Rights of Recipients of Mental Health Services, Regulations for Licensing and Certification of Alcohol and Drug Treatment Services." Determination of resident eligibility is made according to Chapter II, Section 97 of the MaineCare Benefits Manual. Residents who are 18-64 years of age and living in Institutions for Mental Diseases are not eligible under this Appendix. However, the cost of covered services to residents of Institutions for Mental Diseases who are 65 years of age or older can be claimed under this Appendix provided they meet all other requirements for eligibility.

The Department will make payment for any eligible member only if the provider obtains the signature of a physician prescribing covered services prior to the first date of service. The provider must maintain this information as part of the member's record.

The Department will not make payment for residents who are family members of the owner or provider staff providing medical and remedial services.

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1000 INTRODUCTION (cont.)

1040 Scope. Level 1 Residential Care Facilities that provide custodial (e.g. supervision, medication administration, and room and board) services to six or fewer residents and do not provide individualized in-home programming to persons with severe physical or functional disability are not eligible for payment under this Appendix. These facilities are paid on a flat rate basis.

2000 DEFINITIONS

2010 Department as used throughout this Appendix refers to either the Maine Department of Health and Human Services.

2020 Member as used throughout this Appendix refers to an individual who is MaineCare eligible.

2030 Room and Board costs are those costs that are not medical and remedial services as defined in this Appendix, and not allowable costs to Title XIX.

2400 ALLOWABILITY OF COST

2400.1 Salaries and Wages for Direct Service Staff

Allowable costs shall include salaries and wages for direct service staff and services, as defined in Chapter II, Section 97, as listed below:

Registered nurses
Licensed practical nurses
Licensed social workers
Personal care services staff
Other qualified medical and remedial staff
Other qualified mental health staff
Clinical consultant services

All staff must meet qualification requirements specified in Chapter II, Section 97.

It is the responsibility of the PNMI to provide and coordinate all covered services performed by direct care staff listed in this Section to assure that members receive the full range of services necessary to meet members' needs without duplication of services. See MaineCare Benefits Manual (MBM), Chapter II, Section 97, Sections 97.04 and 97.05 regarding covered services and non-duplication of services.

2400.2 A program allowance, expressed as a percentage of the allowable costs, as defined in Chapter III, Section 97, Sections 2400 will be allowed in lieu of indirect and/or PNMI related cost.

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2400 ALLOWABILITY OF COST (cont.)

2400.3 Personal care services include salaries, wages, benefits, and consultant fees for laundry, housekeeping, and dietary services.

The personal care services component is determined by inflating the most recent audited costs for these services to the facility's fiscal year ending after July 1, 2002. This becomes the PNMI's facility-specific personal care cap. The personal care cap is deducted from the facility's routine costs as of July 1, 2002. The actual allowable personal care services costs will be settled at audit up to this facility-specific cap.

2400.4 Tax and Benefit Costs

Allowable costs include, in addition to salaries and wages, the taxes and benefit costs described in Chapter III.

2400.5 Staffing Approvals

The Department shall approve staffing based on the services necessary to carry out individualized service plans at an accepted standard of care. In the case of services that were created as a result of a competitive bidding (request for proposal) process, the provider must deliver the services accepted and approved by the Department during that process. The Department will use the description of the PNMI services, and any additional information from onsite review or surveys of the facility, including payroll information, as the basis for reviewing/approving staff.

2400.51 Additional Requirements for Staffing Approvals

Staffing approvals may, at the discretion of the Department, be accompanied by requirements with regard to admission, discharge and service provision, non-discrimination, reasonable accommodation, dispute resolution procedures, quality improvement practices, access to departmental consultants, training, and other areas as may be required to provide members with a person centered service plan.

2400.52 Audit of Approvals

All approvals are subject to audit. Those staffing hours not utilized for the purpose approved by the Department will be disallowed at audit, either in whole or in part.

2400.6 Consultation Services

Consultation services referred to in this Appendix may be considered as part of the allowable per diem cost, with the prior approval of the Department, in accordance with the following:

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2400 ALLOWABILITY OF COST (cont.)

2400.61 Pharmacy Consultants. Pharmacy consultant services are allowable to the extent required by the applicable licensing regulations.

2400.62 R.N. Consultants. R.N. consultant services are allowable to the extent required by the applicable licensing regulations for residential care facilities. If a provider employs an R.N. as part of approved direct care staffing, the provider shall submit written justification when seeking approval for consultant services.

2400.63 Dietary Consultants. Dietary consultant services shall be allowed for the development of therapeutic diets prescribed by a physician and when necessary to monitor and address specific nutritional problems.

2400.64 Procedure for Requesting Approval of Staffing/Consultant Costs Providers must make written requests for staffing approvals to the Department. The request must explain the circumstances that justify the request and the total cost to implement the request, including wages, taxes and benefits; financial information; specifics related to resident needs; operational costs; and other information as requested by the Department.

2400.65 Denials. Requests will not be approved if they are intended to circumvent limitations established by the Department. All approvals are subject to audit and a test of reasonableness and necessity. Those not utilized for the purpose approved by the Department will be disallowed at audit, either in whole or in part.

2400.7 Department Approved Training

Department-approved training is an allowable cost.

2400.8 Medical Supplies

Medical supplies are an allowable cost.

2400.9 Costs Related to Accreditation

If the Department requires a provider to maintain an accredited status with a recognized accreditation organization, then the costs related to accreditation are allowable.

2400.10 Allowable costs will also include the contract fee paid for use of exchange fellows in lieu of direct service staff as defined in the applicable appendix. Contract fees must be prior-approved by Department. The contract fee paid cannot exceed the normal salary plus benefits and taxes for comparable direct service staff within the provider agency.

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2400 ALLOWABILITY OF COST (cont.)

2410 As of July 1, 2004, allowable costs shall include a State-mandated service tax. The State-mandated service tax is a 5% tax on the value of PNMI services.

2450 PROGRAM ALLOWANCE

2450 Program Allowance: A program allowance, expressed as a percentage of the allowable costs in Sections 2400 through 2410 will be allowed in lieu of indirect and/or PNMI related cost. The program allowance, as set forth in Chapter III, Section 97, is a percentage specific to this Appendix and is applicable to all facilities covered under this Appendix. The program allowance will be 35%.

2500 NON-ALLOWABLE COSTS

Non-allowable costs include room and board costs, as well as all costs not approved under this Appendix.

3000 METHOD OF PAYMENT

3010 Per Diem Rates

For services provided on or after July 1, 2001, the MaineCare per diem rates for existing facilities will be adjusted to add the program allowance and any applicable accreditation costs. The Department will base the rates on an occupancy level that is the greater of actual or 90% of licensed capacity for facilities greater than 6 beds, and the greater of actual or 80% for facilities with 6 or fewer beds. Once the per diem rates are established, this becomes the facility's cap. This cap will be adjusted at time of audit on State-mandated service tax expense, as defined in Chapter III, Section 2410. See MBM, Chapter III, Section 97 regarding inflation adjustments.

3020 New Facilities

For new facilities opening after July 1, 2002, total projected allowable costs approved by the Department will be divided by the estimated annual occupancy, which shall not be less than 90% of the actual licensed capacity for facilities more than 6 beds or 80% in facilities of 6 or fewer beds. The program allowance and costs related to accreditation, if applicable, will then be added to calculate the interim MaineCare rate.

3030 Request for Change

Requests for changes in allowable costs may be made no more often than every 6 months, and only for good cause, except in emergency situations. The Department will not grant retroactive rate adjustments.

3040 Interim Per Diem Rates

Department personnel set interim per diem daily rates as follows:

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3000 METHOD OF PAYMENT (cont.)

3040.1 The Office of MaineCare Services sets interim daily rates for medical and remedial service facilities not participating in the case mix payment system, and funded by the Department of Health and Human Services.

3040.2 The Division of Audit sets interim daily rates for medical and remedial service facilities not participating in the case mix payment system.

3050 Intensive Rehabilitation Services for Individuals with Acquired Brain Injury (ABI)

To be covered under this Appendix, and be exempt from the payment method described in Appendix C, the residential care facility must provide individualized intensive rehabilitative services and supports exclusively to persons with acquired brain injury. The facility must possess characteristics, in terms of staffing, philosophy and physical design, which create a unique unit providing rehabilitative and community support services to ABI residents. Approved staffing shall be reasonable and adequate for an efficiently and economically operated facility.

3050.1 Reimbursement for intensive rehabilitation services is subject to the Request for Proposal (RFP) bidding process and the availability of funding. The Department will approve staffing necessary to carry out the services approved in the bidding process.

3050.2 The provider must acquire and maintain CARF accreditation within 2 years of becoming a MaineCare provider of intensive rehabilitation services under this Section. The cost of CARF accreditation is an additional allowable cost, in accordance with this Section.

3060 Facilities for Persons with HIV/AIDS

To be covered under this Appendix, and be exempt from the payment method described in Appendix C, the residential care facility must provide services exclusively to individuals diagnosed with HIV/AIDS. The facility must possess characteristics, both in terms of staffing, philosophy and physical design, which provides residential support to residents. The provider must have established relationships with home health agencies, hospices and other services for support of individuals.

3070 Facilities For The Blind

To be covered under this Appendix, the residential care facility must provide services exclusively to individuals who are blind and for whom a comprehensive PNMI facilitates and supports each individual's placement and provides opportunities for skills training that would enable residents to move to a less restrictive setting. The facility must possess characteristics, in terms of staffing, philosophy and physical design, which enable residents to achieve optimal functioning.

3080 Facilities for Persons with Severe and Prolonged Mental Illness

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3000 METHOD OF PAYMENT (cont.)

3080.1 To be covered under this Appendix, the provider must serve primarily public wards for whom the Department has a legal responsibility or others with similar programmatic needs. The facilities shall only admit residents with a primary diagnosis of severe and prolonged mental illness. Residents may have functional impairments and behavioral issues. Priorities for admission will be determined in collaboration with the Department. Service plans shall be individualized and person centered.

3080.2 Facilities covered under Section 3080 must have a license as a Mental Health Treatment Facility in addition to a residential care facility license.

3090 Facilities for Persons with Mental Retardation

3090.1 To be covered under this Section, the provider must serve persons who have mental retardation or autism.

3090.2 Facilities must have 4 or more beds and have a MaineCare Provider Agreement with the DHHS.

4000 JUSTIFICATION FOR EXEMPTION

Each provider is required to evidence practices and maintain documentation describing the specialized nature of its services that warrants exclusion from Appendix C. In addition, each provider shall follow a written quality assurance and improvement program that will incorporate feedback from residents, guardians and others.

5000 AUDIT SETTLEMENTS

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Audit settlements will be made based on Principles of Reimbursement, Chapter III and this Appendix.

5010 Reimbursement will be limited to the total actual allowable costs of the facility, not to exceed the maximum prospective rates approved by the Department, including the medical and remedial rate and the personal care services rate.

5020 The lesser of the cost per bed day, or the maximum prospective rate approved by the Department, shall be multiplied by the number of MaineCare eligible days to determine the total MaineCare cost.

5030 Final settlement consists of allowable costs determined through the audit, compared to the interim payments received by the provider.

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6000 INFLATION ADJUSTMENT

Except when there is specific statutory direction, the Commissioner of the Department will determine if an inflation adjustment will be made, the amount of that adjustment, and any performance standards related to that adjustment.